Identifying Trauma-Related Symptoms and Their Corresponding Treatment Interventions

Department of Mental Health

2003 Spring Training Institute

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Jeffrey N. Wherry, Ph.D., ABPP

Children's Advocacy Services of Greater St. Louis

314.516.6798

wherryj@msx.umsl.edu

http://www.safekidsmo.org

Children's Advocacy Services of Greater St. Louis (2000-2001)

- Services
  - Forensic: 275 interviews/71 medical exams
  - Clinical: 172 therapy/47 psychiatric/63 group
- Training
  - Workshops: 1375
  - Practica: 15
  - Classroom: Child Maltreatment/Family Therapy/Rorschach/Victims/Educational Psychology
- Research
  - Dissertations
  - "Clinical" research

Mission

To reduce the trauma experienced by sexually abused children in the Greater St. Louis community

Greater St. Louis Child Traumatic Stress Program

- Providing direct services to children traumatized by
  - Domestic violence
  - Witnessing community violence
  - Physical abuse
  - School violence
  - Homicide
- Consultation
- Training
- Call Jeffrey N. Wherry at (314)516-6798 for more information

Purpose of Today's Presentation

- Present a model for understanding the impact of child trauma
- Consider diagnostic and assessment issues supporting this model
- Make available a series of preliminary findings supporting the reliability and/or validity of measures for assessment of the concepts expressed in this model

Types of Traumas

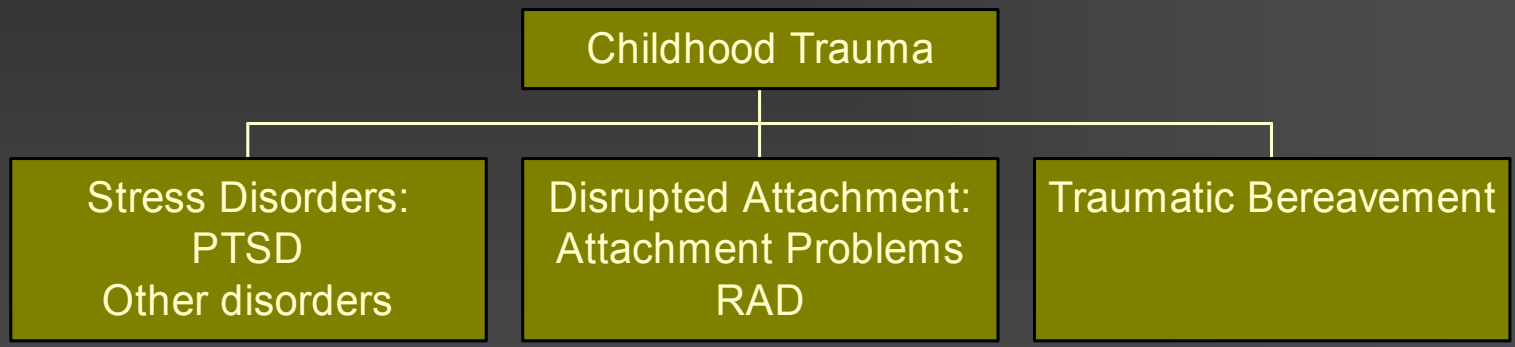
- Natural disasters
- Kidnapping
- School violence
- Community Violence
- Terrorism/War
- Homicide
- Physical Abuse
- Sexual Abuse
- Domestic violence
- Medical procedures
- Victim of crime
- Accidents
- Suicide of loved one
- Extreme Neglect

How Common are Traumatic Experiences?

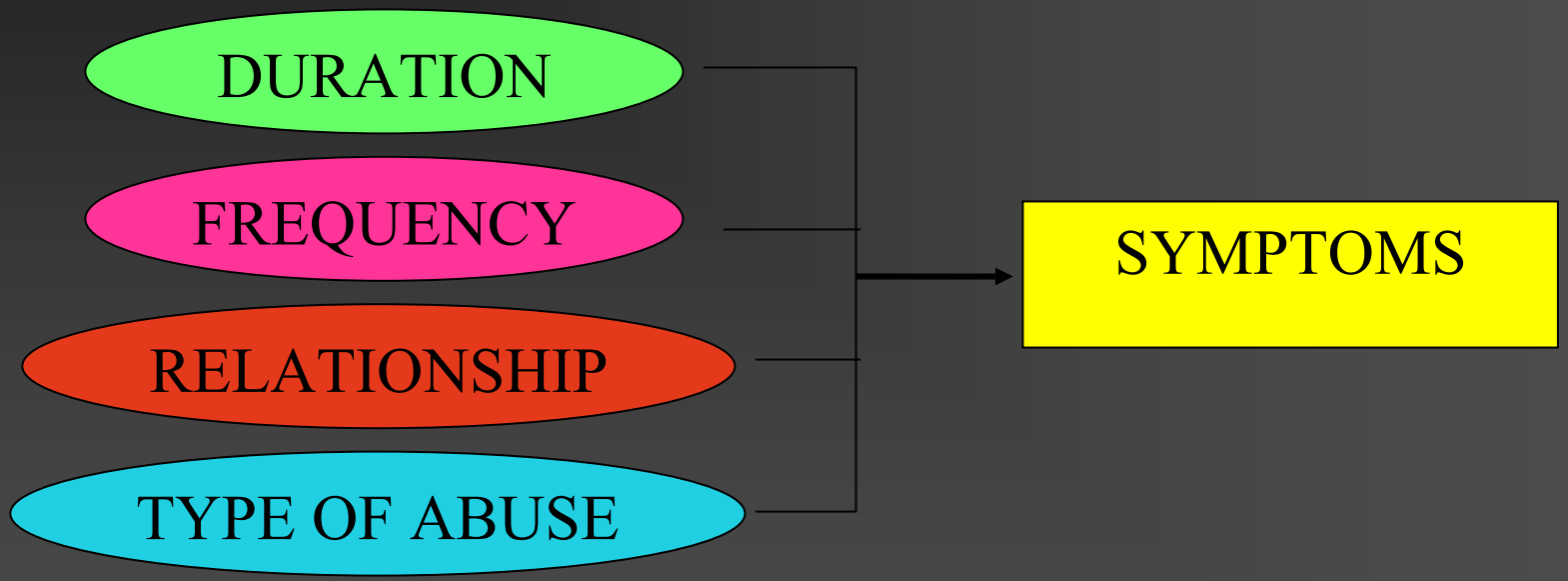
- 69% of the general U.S. population report exposure to one or more life-threatening traumatic events
- 14 to 43% of children report having experienced a traumatic event prior to 18.
- Up to 91% of African American youth in urban settings report violence exposure
- 10% of children under 5 witnessed shooting/stabbing

Effects of Trauma: A Simple History

Effects of Trauma on Children

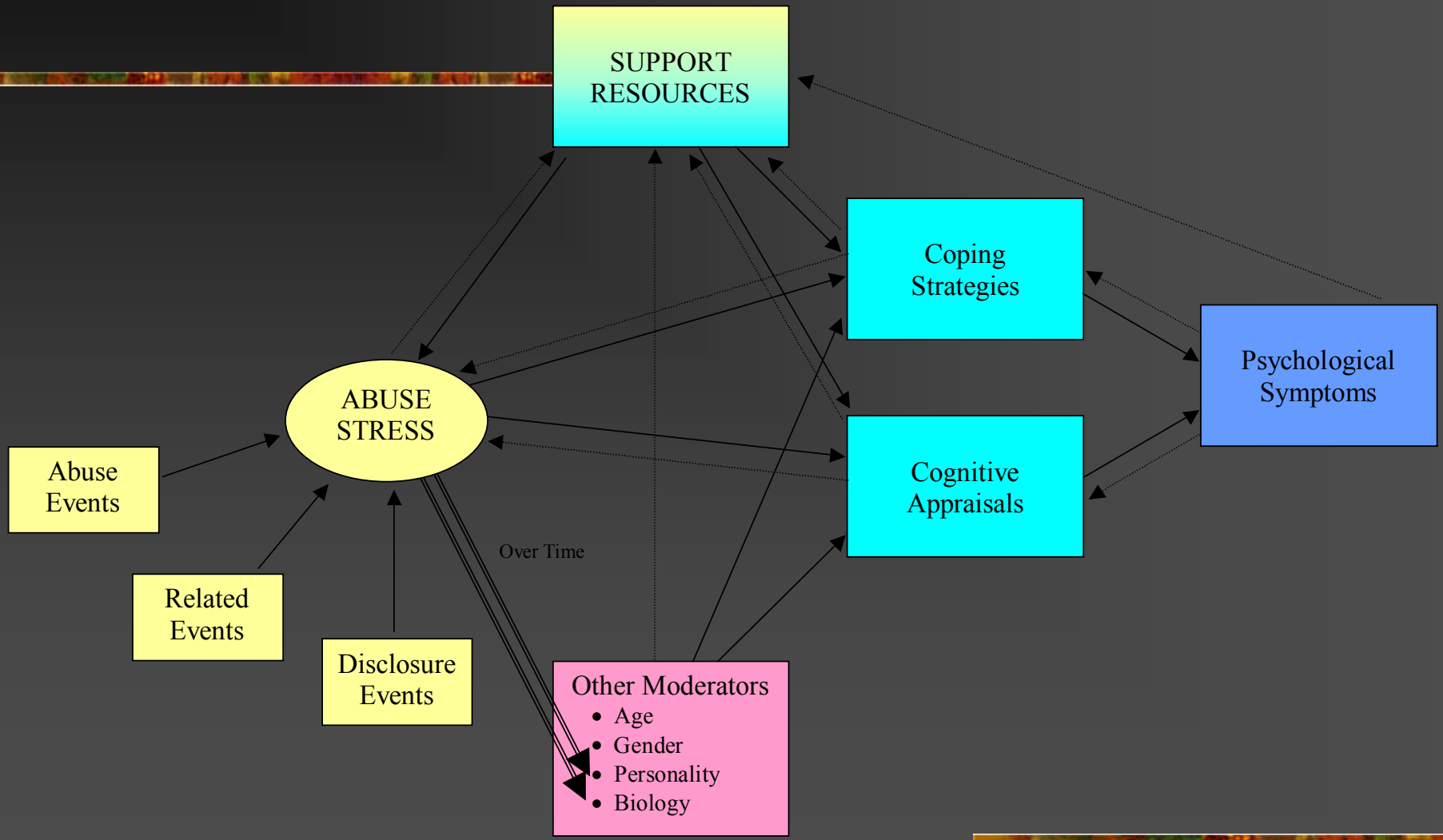


A History of Conceptualization

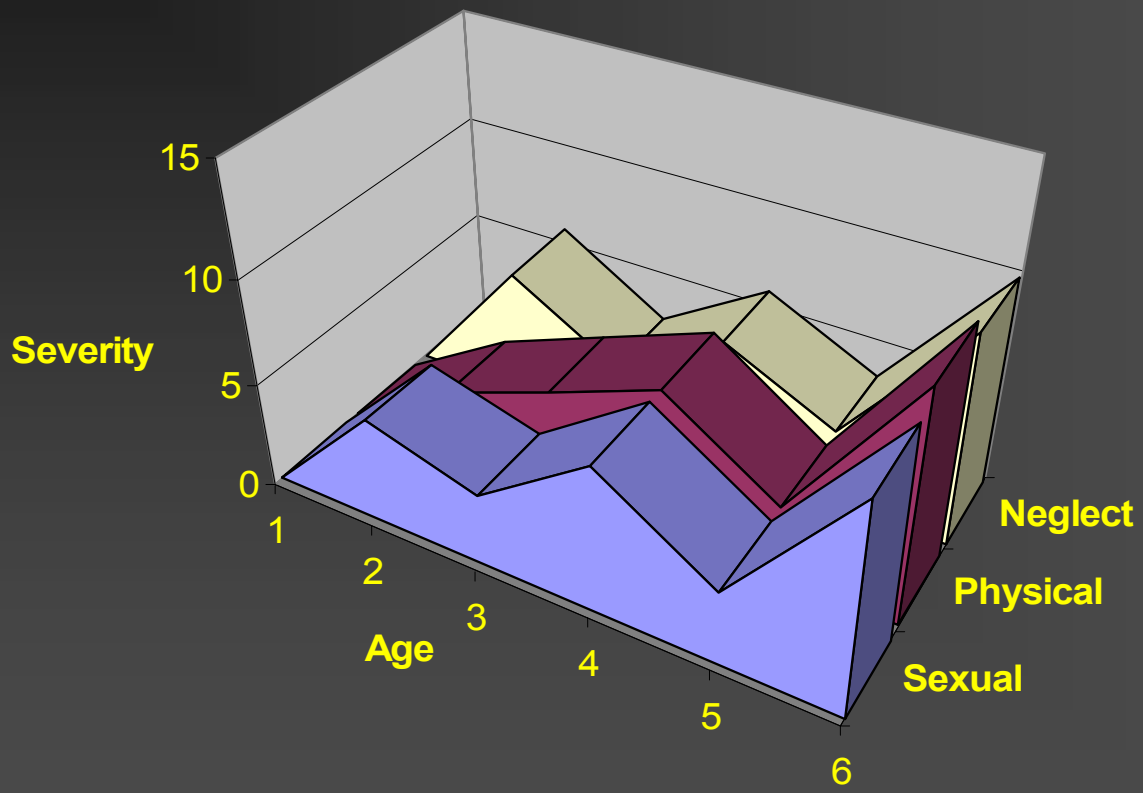


- Trauma, generally, and sexual abuse, specifically, is not a singular experience leading in some simple and direct way to some single symptom or syndrome.

Spaccarelli (1994)



The Effects of Multiple Stressors Over Time



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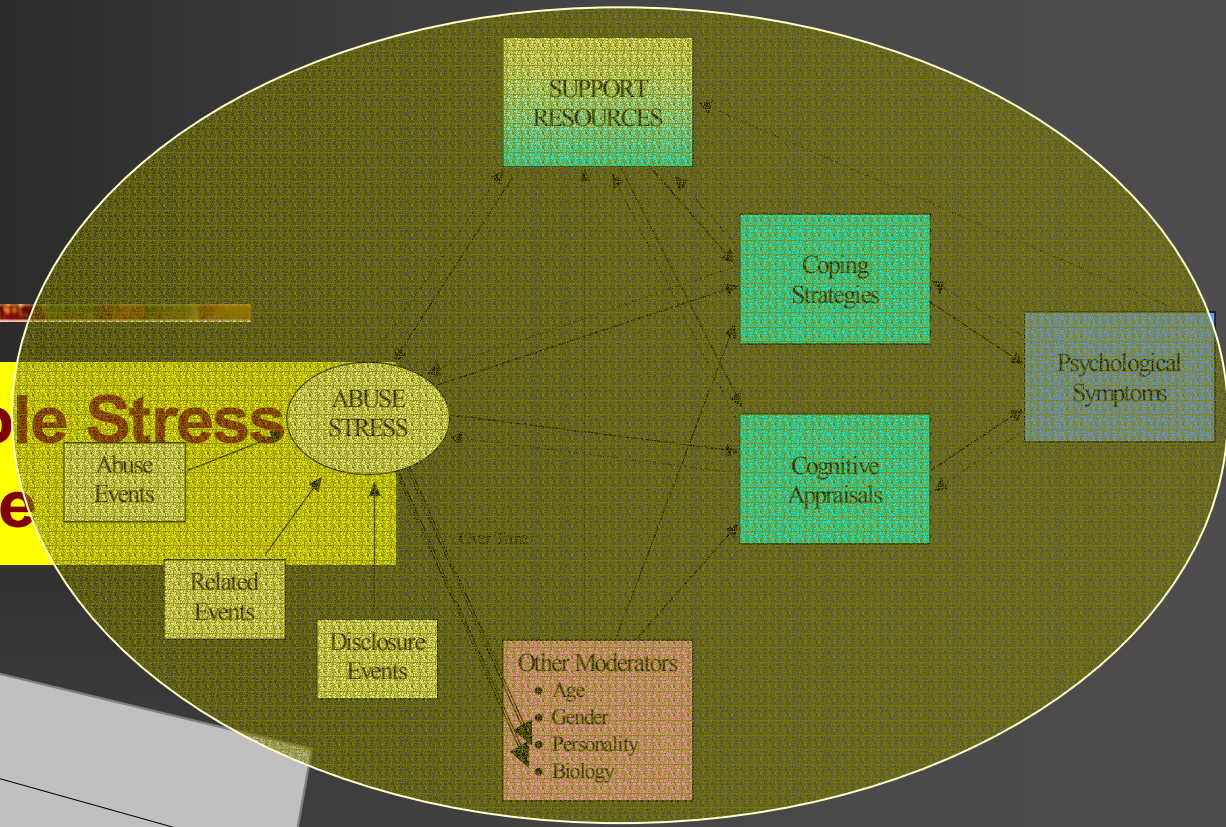

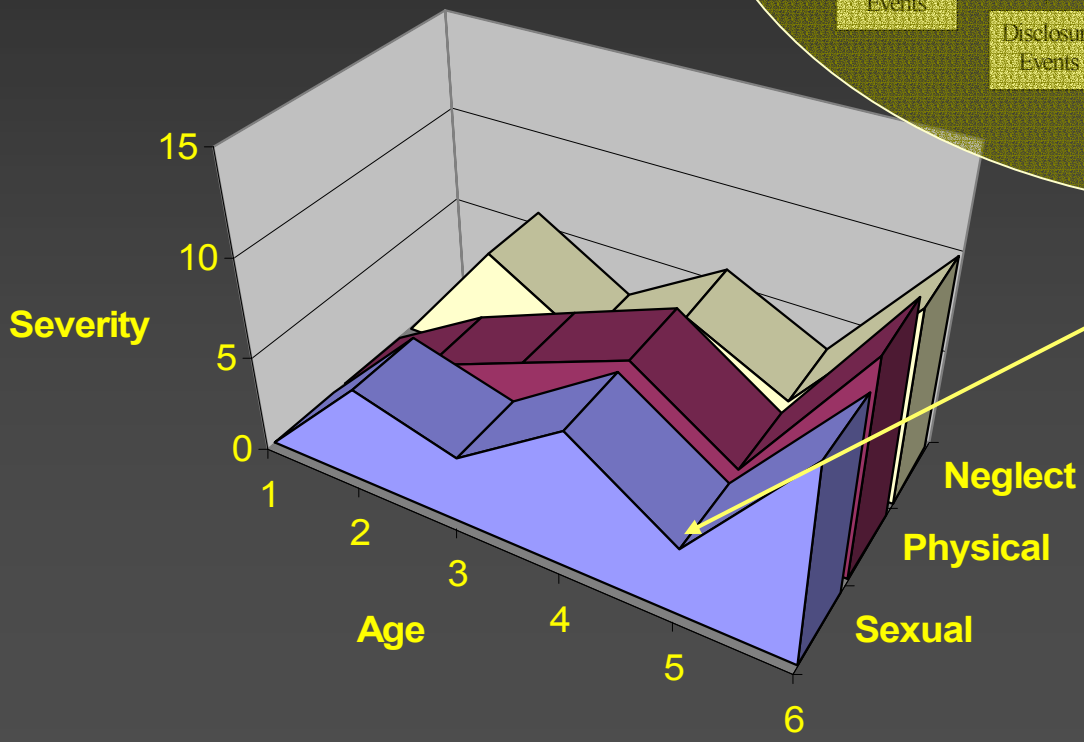

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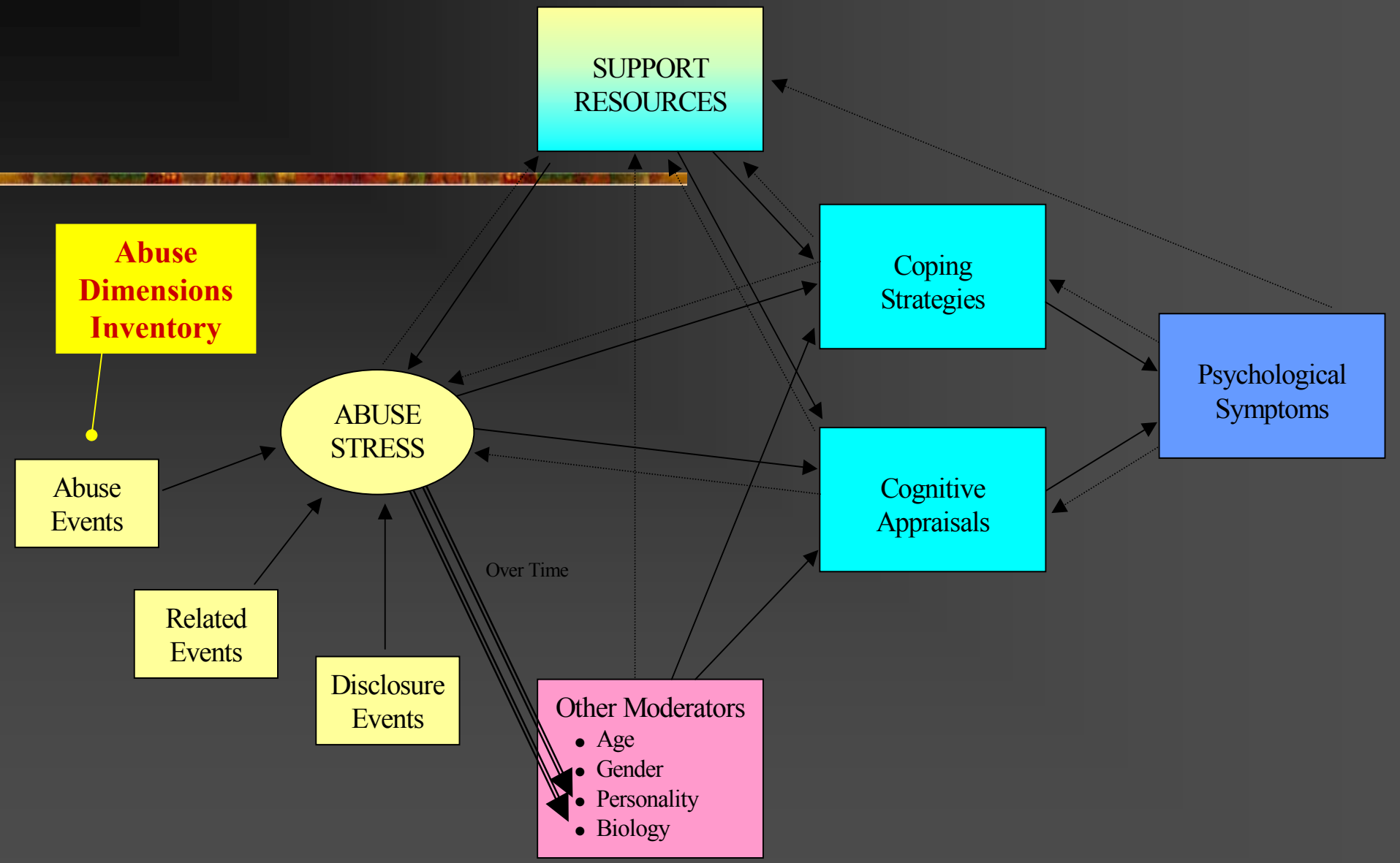
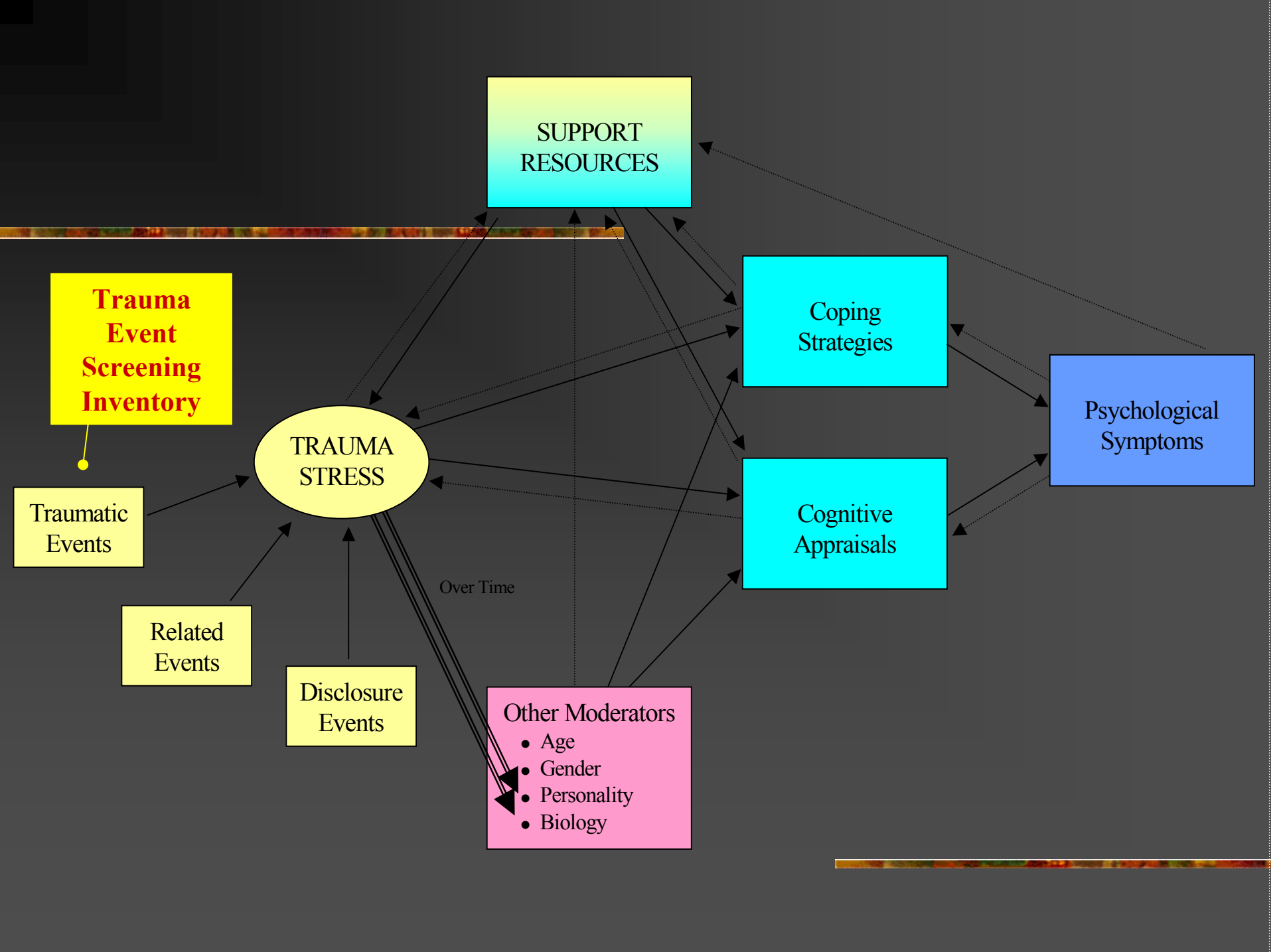

SUPPORT RESOURCES
Abuse Dimensions Inventory
Coping Strategies
Psychological Symptoms
ABUSE STRESS
Abuse Events
Cognitive Appraisals
Over Time
Related Events
Disclosure Events
Other Moderators
Age
Gender
Personality
Biology

Abuse Dimensions Inventory

- Purpose of Measure: Quantify abuse characteristics and severity
- Three Studies
  - Study 1: Examine consensus among professionals in the field regarding abuse severity (absent subjective interpretation by victim)
  - Study 2: Inter-rater reliability of caretaker interviews
  - Study 3: Examination of construct validity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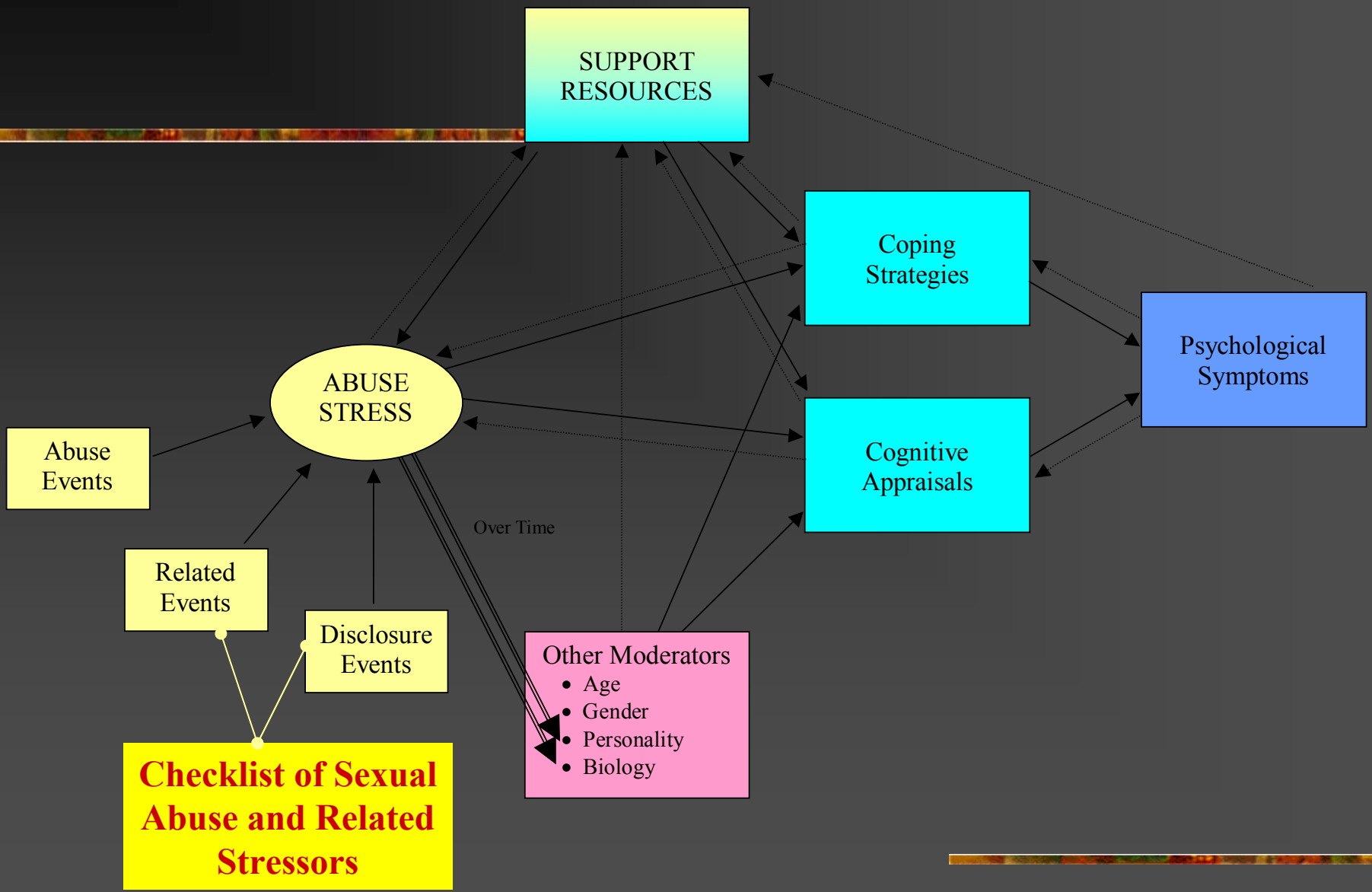
Trauma Exposure Measures for Children and Adolescents

- Traumatic Event Screening Inventory (TESI; Ford, 1996)
- TESI - Parent Report Revised (Ghosh Ippen et al., 2002)
- Youth Trauma Screen (Rodriguez & Lajonchere, 2002)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Checklist of Sexual Abuse and Related Stressors

Predictors of Outcome for Sexually Abused Children

Janelle Vincent O'Boyle

and Jeffrey N. Wherry

Children's Advocacy Services of the University of Missouri-St. Louis

Materials/Procedures

- *The Checklist of Sexual Abuse and Related Stressors* (Spaccarelli, 1995).
  - Assesses the child's report of the occurrence of events related to sexual abuse experiences, including abuse-specific events such as coerciveness and victim denigration, abuse-related events such as family conflict and nonsupportive responses to disclosure, and public disclosure-related events such as repeated interviews and adjudication problems.
  - Convergent validity of this measure has been supported by significant correlations of the C-SARS Total Events score with therapists' overall rating of abuse stress and with victim reports of the number of types of sexual abuse experienced (Spaccarelli, 1995).

Materials/Procedures

- Modified version of the C-SARS (C-SARS for Young Children; O'Boyle, 2000) developed for the younger CSA population
- Child is asked to answer "yes" or "no," indicating the abuse, abuse-related, and disclosure-related events they have experienced.
- The modifications were employed to simplify the language of the C-SARS and to reduce the number of items to an appropriate developmental level for 5- to 12-year-old children.

Percentage of C-SARS **Abuse** Events

Event	*Percentage*
Negative Coercion	69%
Inducements	81%
Trust violations (e.g., lies)	60%
Stigmatizing Messages	70%

Percentage of C-SARS Abuse-**Related** Events

Event	*Percentage*
Family Conflict	52%
Loss of Social Contacts	93%
Non-supportive Responses	97%

Percentage of C-SARS **Disclosure**-Related Events

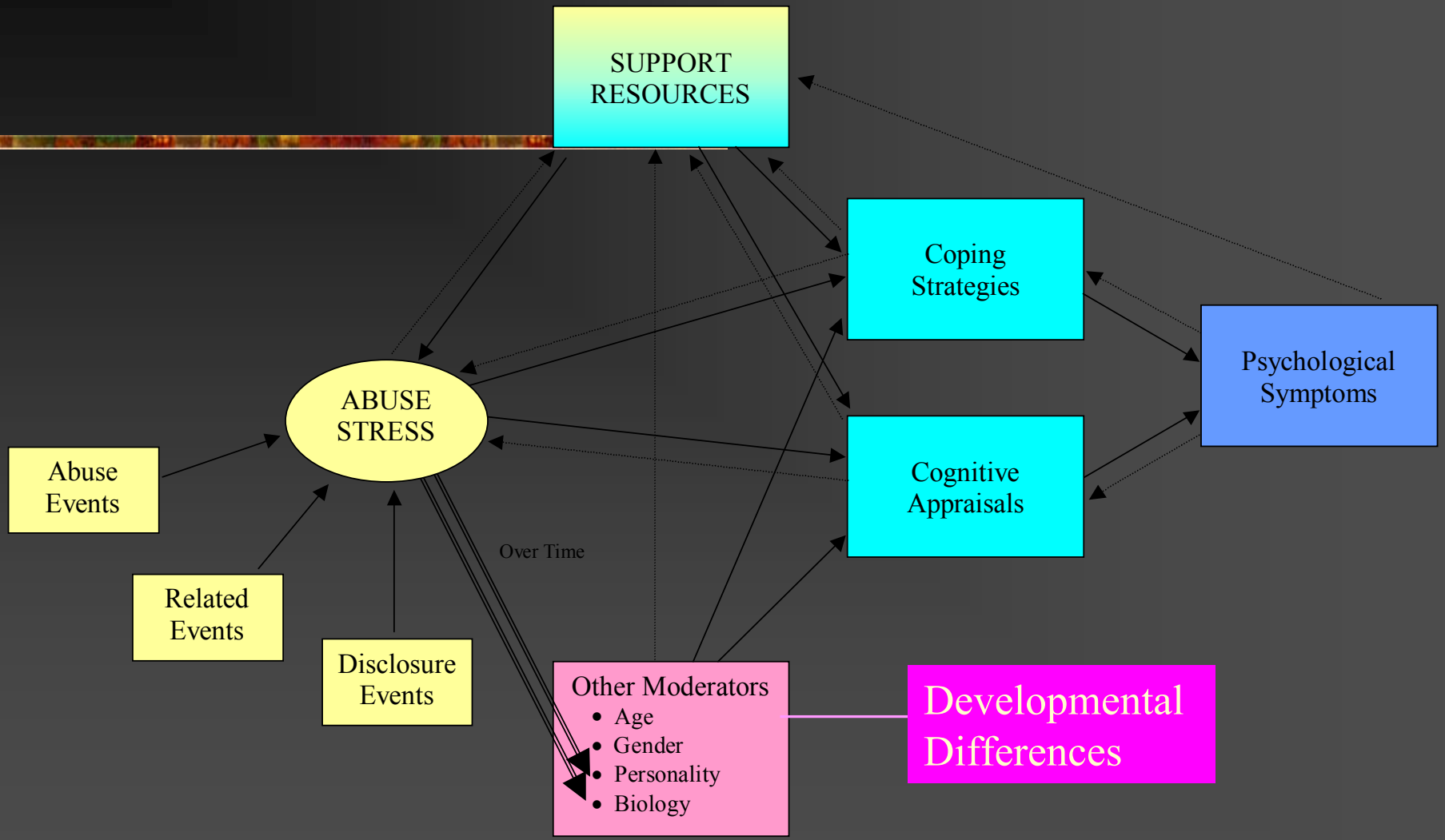
Event	*Percentage*
Investigation Difficulties	74%
Dislocation	29%
Legal System Difficulties	29%

Multiple Regression

- Multiple regression analyses examined relationships between the predictor variables (i.e., child's age, abuse events, disclosure events, and related events) and the DVs (i.e., CBCL scores and CSBI scores).
- All were nonsignificant except age & related events being predictive for CBCL Internalizing raw scores.
  - When age, abuse events, disclosure events, and related events were entered into the prediction equation for CBCL Internalizing raw scores, the model was significant, $F(4,57) = 5.05$, $p = .002$
  - Being older and experiencing more related events were related to increased caregiver ratings of CBCL Internalizing scores (see Table 3).

Discussion

- Age and related events were significant predictors of internalizing ratings obtained by caregivers.
- While age of a victim cannot be modified, related events can be modified. Thus, caseworkers and the systems involved early with sexually abused children should do all that is possible to address
  - *family conflict,*
  - *lack of social contact, and*
  - *non-supportive responses to the disclosure*.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Developmental Differences

Developmental Differences in Responses to Trauma

- Infants and Toddlers (0 to 3)
- Preschool Children (4 to 6)
- School-age Children (7 to 12)

-Marans & Adelman (1997)

-Scheeringa (1995, 2000)

Infants and Toddlers

- Pattern #1: Withdraws, rejects affection, stops exploring environment, lacks trust in others,appears “unattached”
- Pattern #2: Clingy, anxious, sleep disturbances, toileting problems, temper tantrums, regressed, disorganized, rages/aggression, crying/irritability

Preschool Children

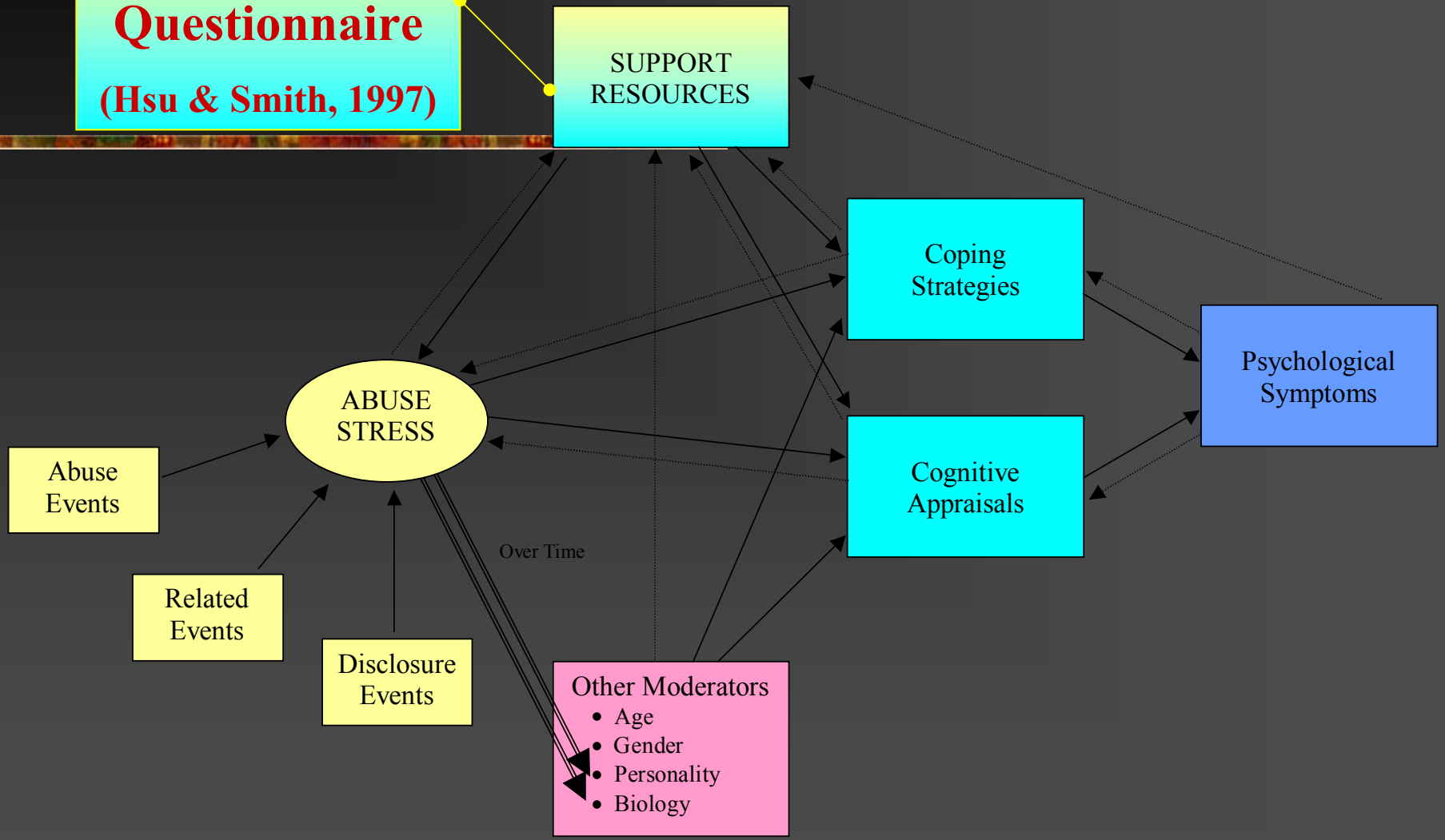
- Regressive behaviors
- Separation fears
- Eating and sleeping disturbances
- Physical aches and pains
- Crying/irritability
- Appearing “frozen” or moving aimlessly
- Perseverative, ritualistic play
- Fearful avoidance and phobic reactions
- Magical thinking related to trauma

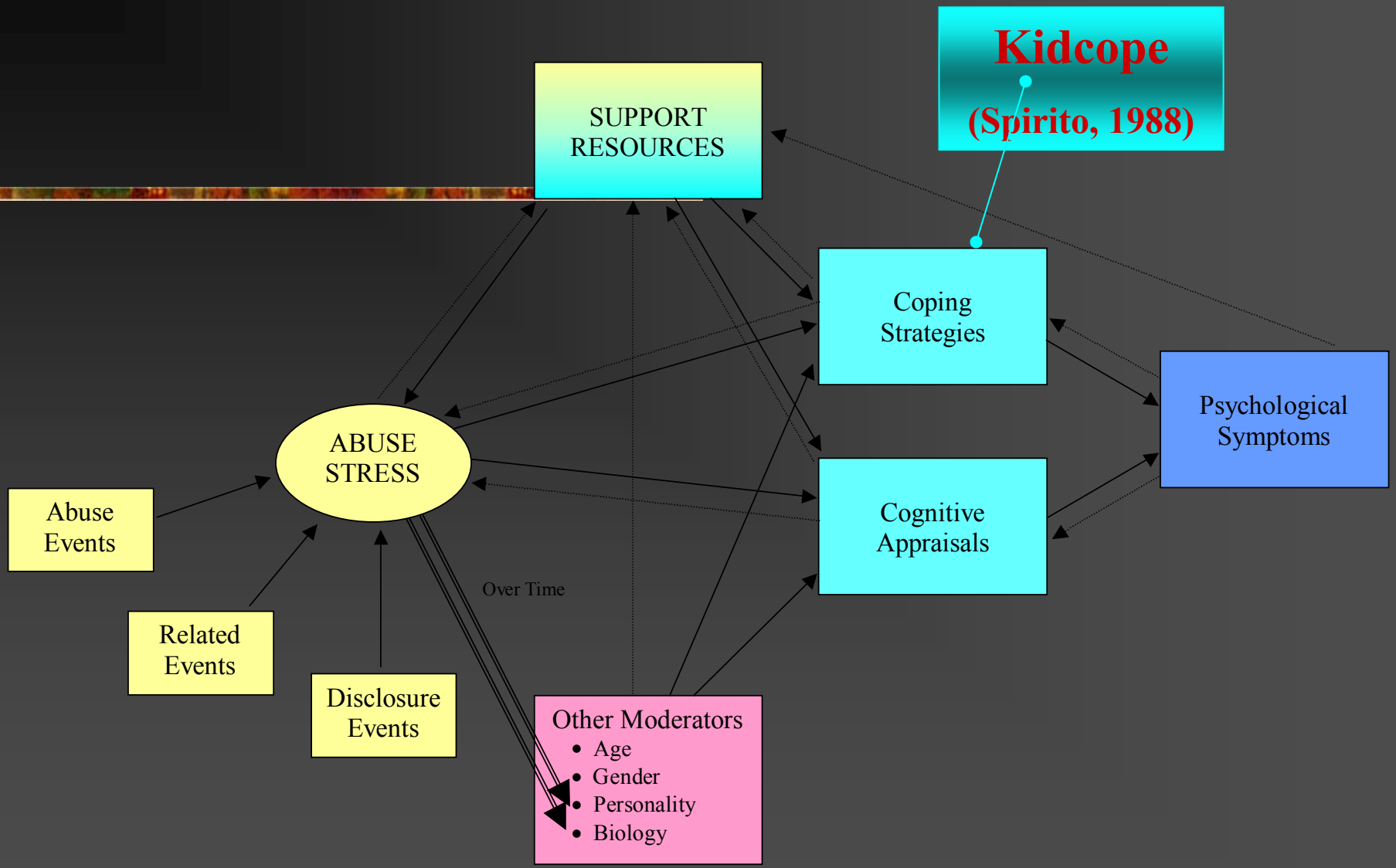
School-Age Children

- Sadness, crying, irritability, aggression
- Nightmares
- Trauma themes in play/art/conversation
- School avoidance > school failure
- Physical complaints
- Poor concentration
- Regressive behavior
- Eating/sleeping changes
- Attention-seeking behavior
- Withdrawal

Maternal Social Support Questionnaire

(Hsu & Smith, 1997)

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(Spirito, 1988)
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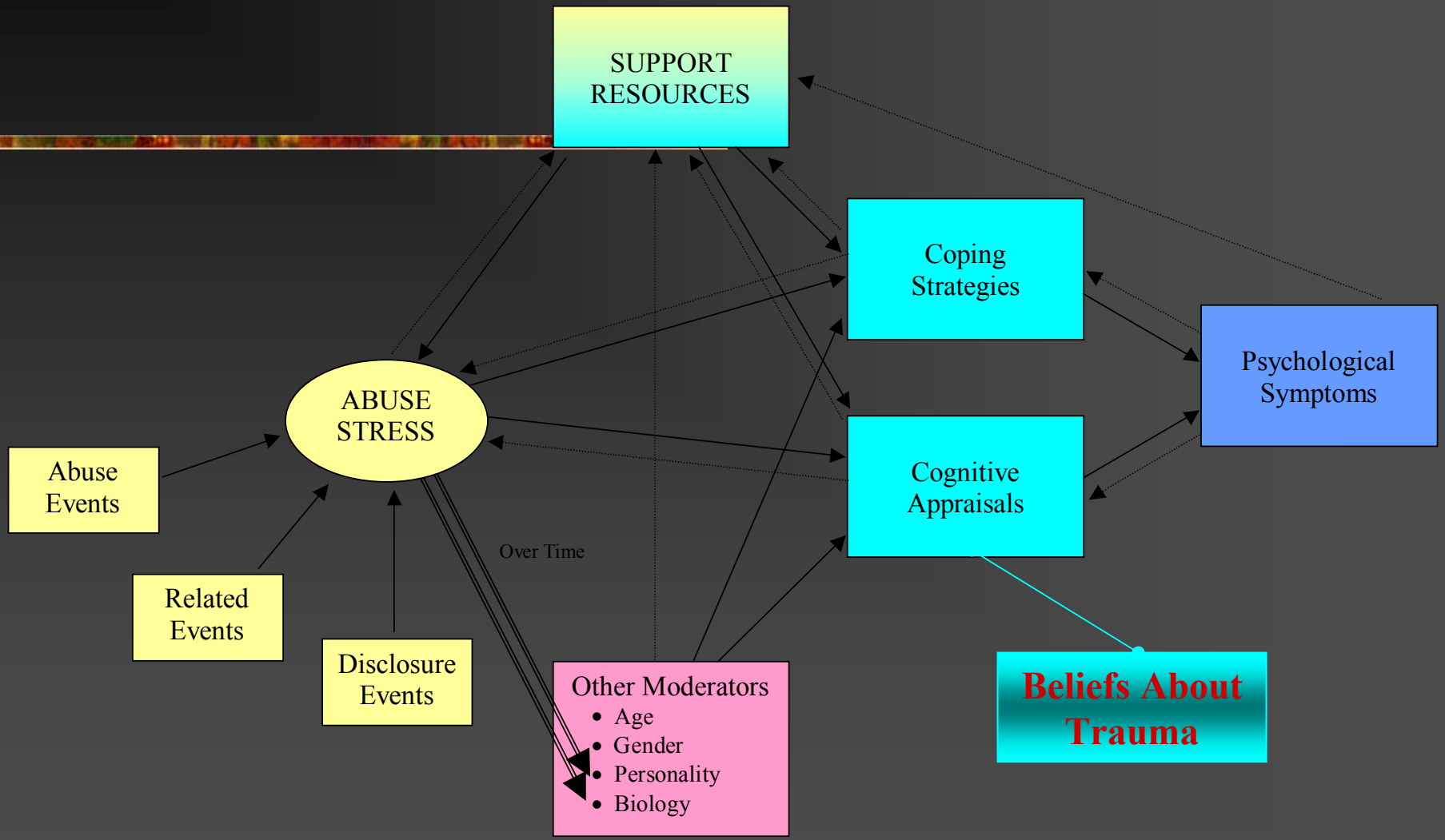
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Beliefs About Trauma

Cognitive Appraisals in Sexually Abused Children

Leslie A. Kimball, Ph.D.
Janelle Vincent O'Boyle, Ed.D., LPC
Lisa Workman, B.A.
Logan Roberts, B.S.W.

Children's Advocacy Services of Greater St. Louis
University of Missouri-St. Louis

Introduction

- We know from cognitive and trauma theories that:
  - Trauma in general, and sexual abuse in particular, often result in changes in victims' basic assumptions about themselves, others, and the world
  - These changes often result in emotional distress and problems in daily functioning
  - These cognitive appraisals can be modified in therapy

Introduction

- Recent research has focused on cognitive appraisals in children, specifically children who have been physically and sexually abused
  - Attributions impact subsequent functioning
  - However, research is still needed to differentiate between abuse-specific and general cognitive appraisals and to determine how to translate this knowledge into treatment interventions

Purpose of Research

- Development of valid and reliable measure of cognitive appraisals specifically for sexually abused children
  - Previous measures have addressed attributions common to physically *and* sexually abused children
  - Previous measures have not been able to compare general cognitive appraisals with abuse-specific cognitive appraisals

Method

- Materials
  - Beliefs about Trauma-G (Kimball, Wherry, and Wise, 2000)
    - 20 items measuring children's cognitive appraisals about "bad things" in general
    - Scored on a three-option Likert scale (Not at all true, A little true, A lot true)
    - Items cover the following themes: Recognizing danger, reactions of family or others, seeking help, control, failing to protect self or others, perceived safety, and general blame and/or responsibility
    - Item construction was a two-step process:
      - First, a list of potential items was generated from the literature on general attributions about trauma, specifically interpersonal trauma, in children and adults
      - Second, items were chosen to address internal vs. external attributions and global vs. specific attributions, and to be more applicable to children

Method

- Materials
  - Beliefs about Trauma-T (Wherry, Kimball, and Wise, 2000)
    - 33 items measuring cognitive appraisals about sexual abuse in children
    - Scored on a three-option Likert scale (Not at all true, a little true, a lot true)
    - Items cover the following themes: Failing to recognize danger, reactions of family or others, seeking help, control, failing to protect self or others, perceived safety, recovery/future, general blame/responsibility
    - Item construction was a two-step process:
      - First, a list of potential items was generated from the literature on attributions in sexually abused children and adults
      - Second, items were chosen to address internal vs. external attributions and global vs. specific attributions, and to be more applicable to children

Method

- Procedure
  - Measures were administered as part of an intake assessment during the first 2 to 3 sessions of individual therapy
  - An intake clinician met with each child and nonoffending parent separately to administer intake measures
  - All children were referred for therapy at the Children's Advocacy Center on University of Missouri-St. Louis' campus to address issues related to sexual abuse

Results

- Reliability
  - BAT-G (n = 60), standardized item alpha = .74
  - BAT-T (n = 55), standardized item alpha = .80
- Validity
  - At this time, we do not have a large enough N to do factor analyses or compare the BAT to other measures (such as the TSCC or the CAPS [Mannarino, Cohen, & Berman, 1994])

Validity

Method

- Participants
  - N = 34 sexually abused children
    - Criteria for inclusion
      - Abuse substantiated by DFS
      - Child acknowledges sexual abuse
    - Age
      - Range = 5 years to 17 years
      - Mean = 10.13; SD=3.13
    - Gender
      - 21% male
      - 79% female
    - Ethnicity
      - 52% Caucasian
      - 45% African American
      - 3% Other

Mean and SD for BAT-A and BAT-T Total and Domain

	BAT-A		BAT-T	
	Mean	SD	Mean	SD
Total Score	14.95	4.36	16.59	5.80
No Recognition	1.82	.93	1.74	1.14
Reactions	.53	.69	2.12	1.45
Seeking help	1.47	.60	1.38	.65
Control	3.37	1.26	2.41	1.37
Perceived Safety	2.55	1.18	2.65	1.35
Blame	1.53	1.25	.29	.63

Mean and SD for Separate BAT-T Domains

	BAT-T	
	Mean	SD
Recovery	4.56	1.46
Failing to protect	1.44	.71

Correlations for the BAT and CAPS

	BAT-A	BAT-T
CAPS	.38[1]	.39[1]
Feeling Different	.41*	.20
Personal Attribute	.39*	.47*
Credibility	.05	.23
Trust	.34	.38[1]

*p<.05

[1] p=.06

Correlations for the BAT and TSCC Raw Scores

	BAT-A	BAT-T
TSCC Factor		
Anxiety	.33*	.41*
Depression	.43*	.32*
Anger	.40*	.37*
PTS	.23	.00
Dissociation	.34*	.27
Overt Dissoc	.34*	.23

*p<.05

Correlations Between Domains of the BAT-A and BAT-T

Domain	Correlation	Significance
Failure to Recognize	.25	.07
Reactions of Others	.38	.01
Seeking Help	.08	.32
Control	.35	.02
Perceived Safety	.42	.01
Blame	.51	.001
Total	.15	.41

Discussion

- The BAT-A and BAT-T are correlated at the .06 level with the CAPS
- The BAT-A and BAT-T are significantly correlated with the Personal Attribution for Negative Event items of the CAPS
- The BAT-A is significantly correlated with the Feeling Different from Other Children items of the CAPS

Discussion

- TSCC Anxiety, Depression, and Anger scores are correlated with BAT-A and BAT-T scores
- Dissociation scores of the TSCC are correlated with the BAT-A

Discussion

- The Domains of the BAT-A and BAT-T are significantly correlated with the exception of
  - Seeking Help
  - Failure to Recognize

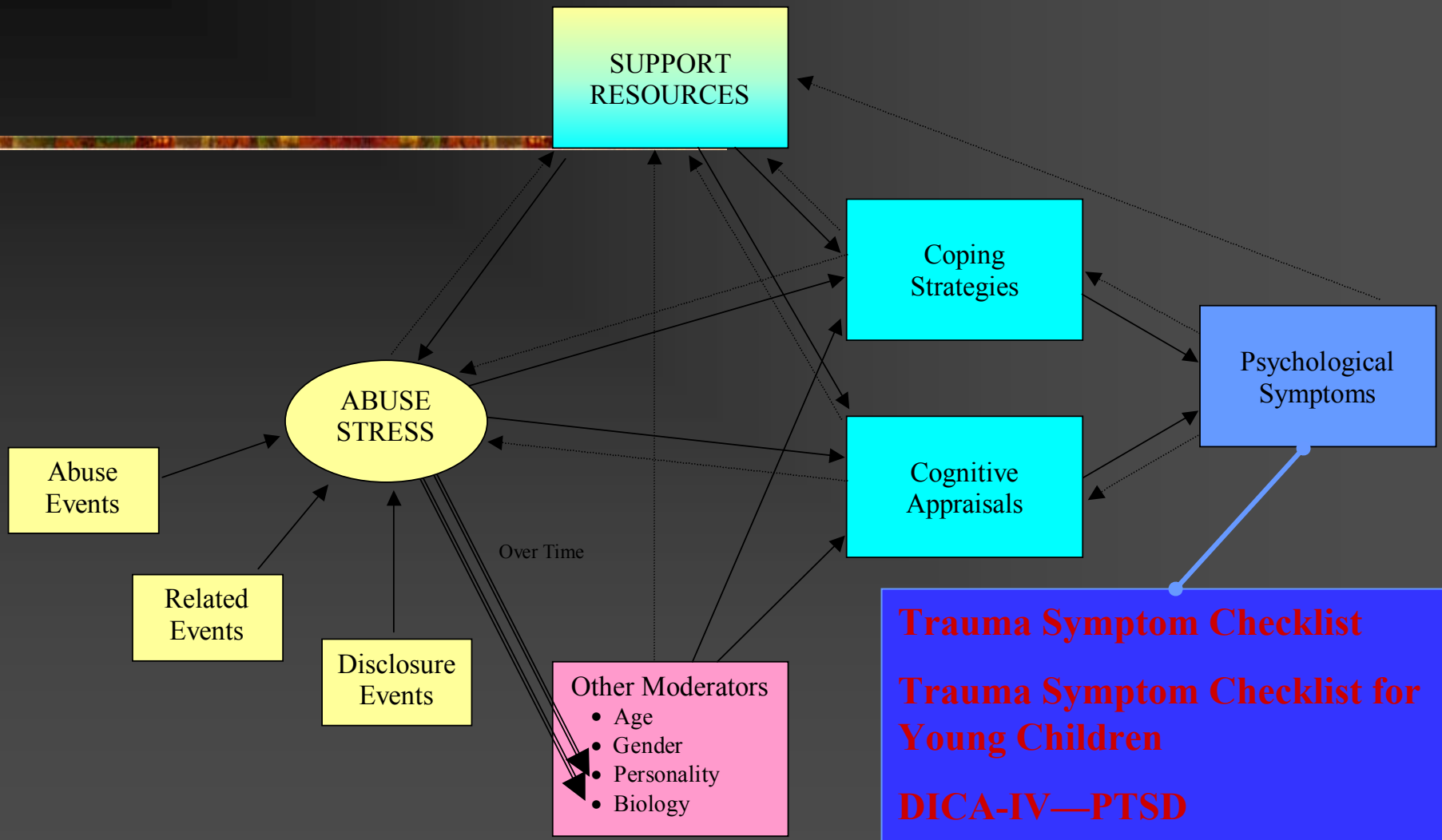
Thus, general attitudes related to seeking help and recognizing danger are not related to the specific experience of sexual abuse

Conclusions

- The BAT-A may hold promise for assessing attributions of children
- The BAT- may hold promise for assessing attributions related to sexual abuse specifically in children

Limitations and Future Directions

- With additional data, a factor analysis would help to eliminate less useful items
- The BAT-A should be administered to normal controls and compared to abused children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Trauma Symptom Checklist
Trauma Symptom Checklist for Young Children
DICA-IV—PTSD
Child Sexual Behavior Inventory
Child Behavior Checklist

Trauma Symptom Checklist for Children (and TSC for Young Children—TSCYC)

http://www.johnbriere.com/psych_tests.htm

The Concurrent Validity of the Trauma Symptom Checklist for Young Children

Jeffrey N.Wherry, Janelle Vincent O'Boyle, Timothy Lyons, and Mariaimee' Gonzalez

Children's Advocacy Services of the University of Missouri-St. Louis

The Trauma Symptom Checklist for Young Children (TSCYC)

- Briere (1999) has developed the Trauma Symptom Checklist for Young Children (TSCYC) which allows a care-taker to rate trauma-related symptoms in young children.
- Data on validity of the TSCYC have not been published.

The current study assesses the concurrent validity of the TSCYC in relation to the TSCC & CBCL.

Materials

- Trauma Symptom Checklist (TSCC; Briere, 1989)
- Trauma Symptom Checklist for Young Children (TSCYC; Briere, 1999)
- Child Behavior Checklist (Achenbach, 1991)

Correlations:Child/Parent

- Raw scores from the TSCC, the CBCL, and the TSCYC were correlated to determine the strength of relationship between scales purporting to measure similar behaviors.
- Correlation coefficients were nonsignificant when self-report factors (TSCC) were compared to parent ratings (TSCYC), with the exception of the Anxious Factor (r=.308, p<.05).

Table 1--Correlations Between Raw Scores for TSCC & TSCYC Factors

			TSCC			
TSCYC	1	2	3	4	5	6
1. Anger	.131					
2. Sexual Concerns		.259				
3. Anxious			.308*			
4. Depressed				.127		
5. PTSD					-.089	
6. Dissociation						.230

*$p<.05$

Correlations: Parent/Parent

- Correlations between the CBCL and the TSCYC were high for all factors ($p<.001$) and accounted for 35-72% of the variance.

Table 2--Correlations Between the Raw Scores for CBCL & TSCYC Factors

		CBCL		
TSCYC	Delinquency	Aggression	Sexual Concerns	Anxious/ Depressed
Anger	.587***	.846***		
Sex Concerns			.685***	
Anxious				.681***
Depressed				.752***

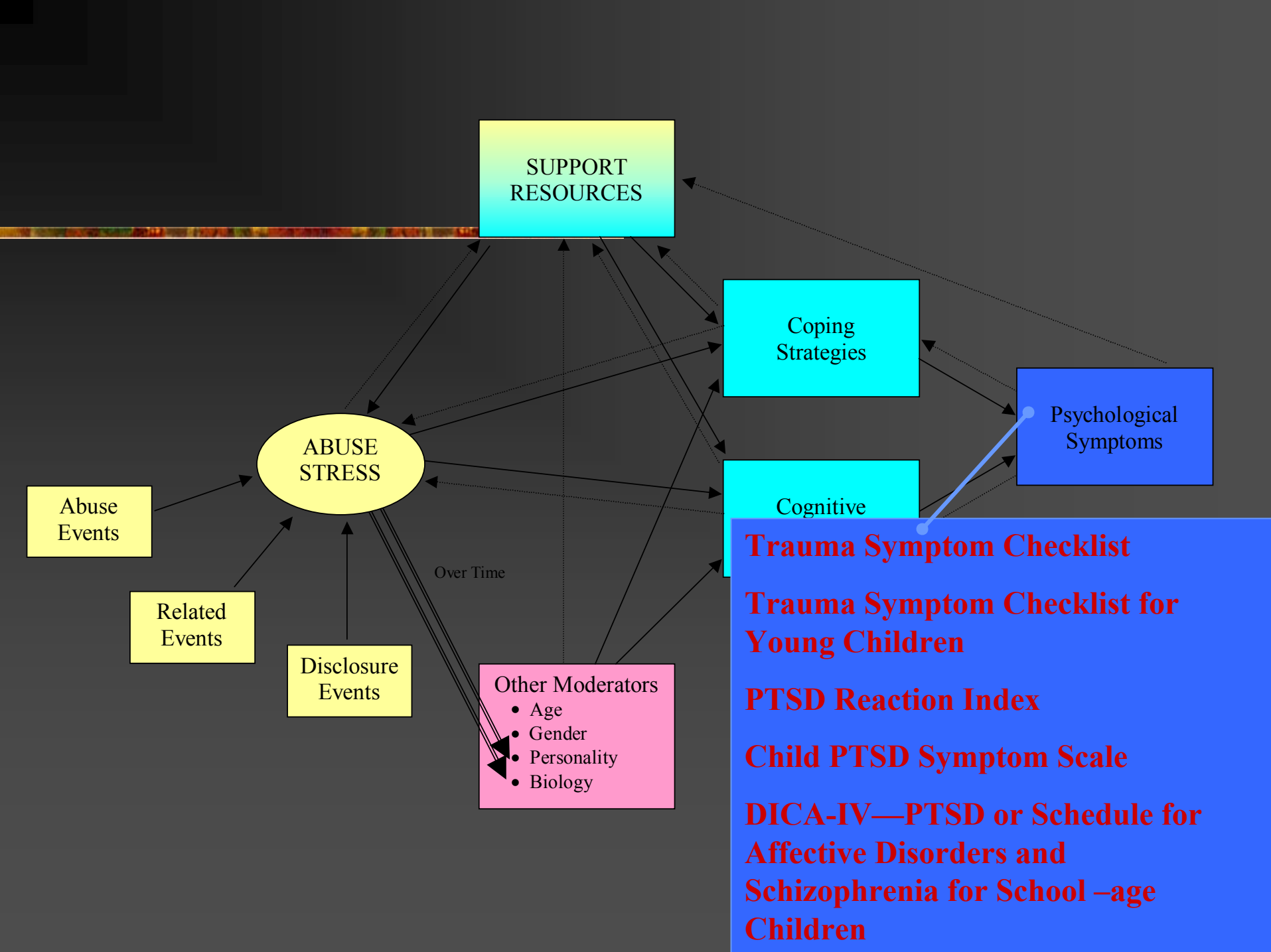
***$p<.001$

Discussion

- These results support the concurrent validity of the TSCYC Scales of Anger, Sexual Concerns, Anxious, and Depressed when compared to the CBCL.
- However, when compared to the TSCC, there was concurrent validity only for the TSCYC Anxious Scale.

Discussion

- Different and larger samples may yield more promising results for the PTSD and Dissociation factors.
- However, the concurrent validity of the Anger, Sexual Concerns, Anxious, and Depressed Factors supports the use of the TSCYC in lieu of the CBCL.
- The nonsignificant relationships between the TSCC and TSCYC scales may be related to the lack of agreement inherent between self-report and parent ratings.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PTSD Reaction Index
Child PTSD Symptom Scale
DICA-IV—PTSD or Schedule for Affective Disorders and Schizophrenia for School –age Children

Assessing Posttraumatic Stress Disorder Using the Trauma Symptom Checklist for Young Children

Elisabeth S. Pollio, L. Ellen Glover-Orr, and Jeffrey N. Wherry

Children's Advocacy Services of Greater St. Louis

University of Missouri-St. Louis

Introduction

- PTSD is a common outcome of sexual abuse among children
- Assessment obstacles related to developmental level make parent report critical for accurate diagnosis
- Structured interviews often not practical in a clinical setting; need for effective screening measure for children
- Purpose of study to assess the ability of the TSCYC to correctly classify PTSD in sexually abused children

Measures

- TSCYC
  - 90-item parent report measure of trauma symptoms in children ages 3 to 12
  - Clinical scales including PTS, anxiety, depression, sexual concerns, dissociation, and anger/aggression
  - Clinical scale alphas from .81 to .93 (Briere, 1999)
- Diagnostic Interview for Children and Adolescents (DICA)
  - Semi-structured interview yielding DSM diagnoses
  - Parallel parent and child forms
  - Good reliability and validity for PTSD diagnosis (Reich, 2000)

Results

- No significant differences found based on age, gender, or race
- Overall reliability .95, clinical scales ranging from .73 (PTS-Avoidance) to .92 (PTS-Total)
- Significant correlations among PTS scales and with Anxiety and Depression
- 22 PTSD-negative (67%) and 11 PTSD-positive (33%) participants
- PTSD-positive significantly higher on PTS-Intrusion, Arousal, and Total

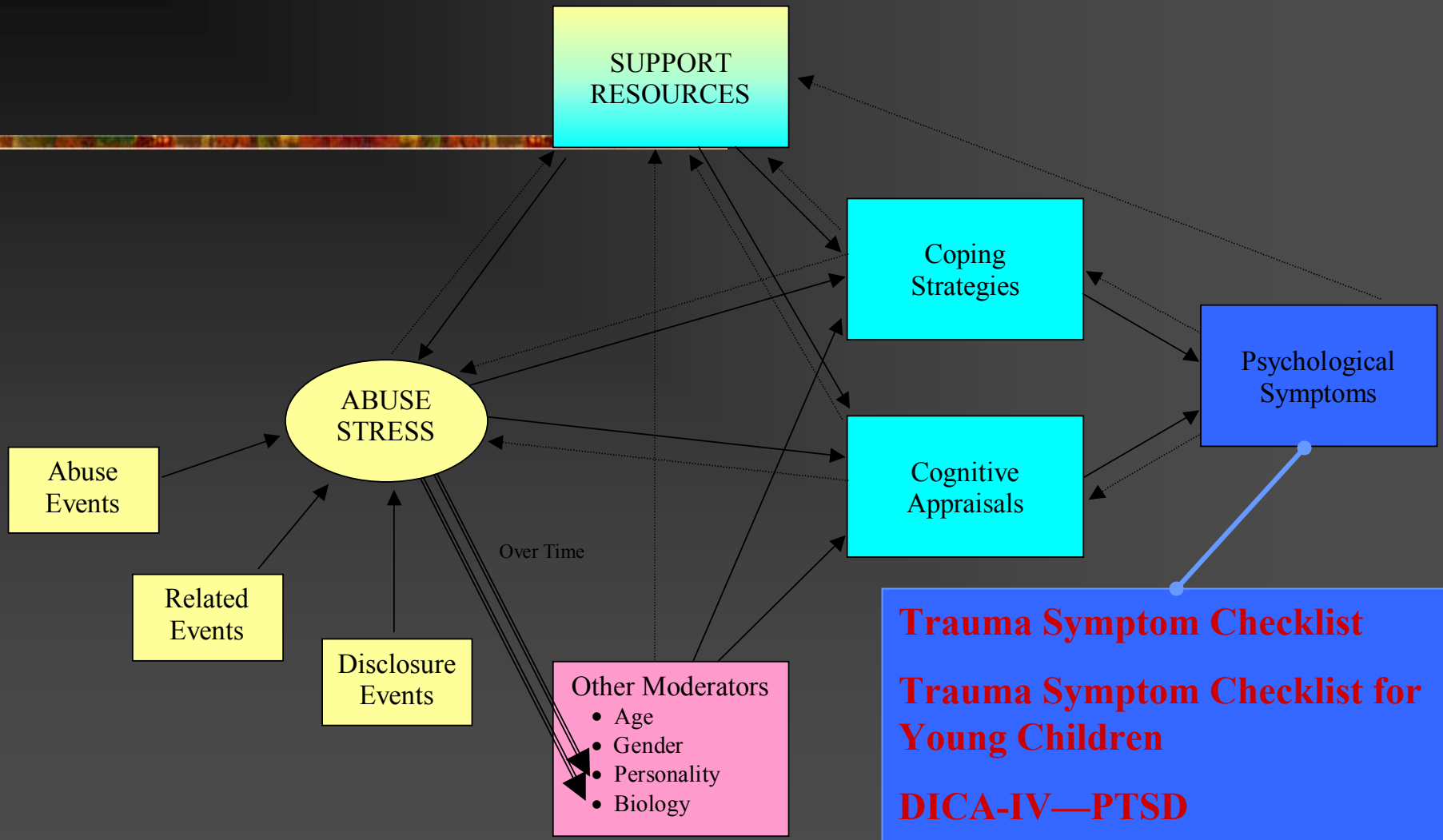
Discussion

- TSCYC scales, together, have 100% specificity and 73% sensitivity
- Results of PTSD diagnoses approximate the DICA-Parent
- More efficient and economical than a structured interview
- Suggests TSCYC is an effective screening device for PTSD in children

DSM-IV Criteria for PTSD by DICA Parent Report*

Category	Percent
Arousal	89%
Re-experiencing	84%
Avoidance	53%
Full Diagnosis	47%

*Pollio (2002): 57 sexually abused children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PSYCHOLOGICAL

SYMPTOMS/DIAGNOSES

When Stress Symptoms Become a Disorder

- Acute Stress Disorder (ASD)
- Posttraumatic Stress Disorder (PTSD)
- Depression
- Anxiety
- Attachment problems (RAD)
- Behavior problems

Primary Symptoms of ASD and PTSD

- Reexperiencing
- Avoidance
- Hyperarousal
- Dissociation

Re-experiencing Symptoms

- Child “re-lives” sensations of traumatic event through intrusive memories, nightmares, flashbacks, hallucinations, and reenactment
- Emotional and physical distress when reminded of the trauma

Avoidance Symptoms

- Avoid all reminders of the traumatic event in an effort to reduce distress
- Avoidance of feelings through emotional “shut down” (a.k.a. dissociation)
- Withdrawal
- Sense of a foreshortened future

Dissociation

- Feelings of unreality (“in a daze”)
- Emotional numbing, detachment

Hyperarousal Symptoms

- Significant increase in physical arousal that was not present before trauma
- Sleep difficulties, irritability, aggression, concentration difficulties, motor rest-lessness, hypervigilance, exaggerated startle response

Acute Stress Disorder (ASD)

- Symptoms of reexperiencing, avoidance, hyperarousal, and dissociation (feelings of unreality or emotional numbing)
- Within the first month after a traumatic event

Posttraumatic Stress Disorder (PTSD)

- Symptoms of reexperiencing, avoidance/dissociation, hyperarousal
- Symptoms present one month after traumatic event

Associated Symptoms of PTSD

- Fears and worries
- Depressive symptoms
- School difficulties
- Physical symptoms
- Regressive behaviors
- Behavioral difficulties

How Common is PTSD?

- On average, 24% of adults exposed to trauma develop PTSD
- In children and adolescents, 3 to 15% of girls and 1 to 6% of boys exposed to trauma could be diagnosed with PTSD
- As a whole, about 6-8% of children in the U.S. will develop PTSD in childhood
- About 50% recover in the first 3 months

Other Stress-Related Disorders

- 80% of people with PTSD also meet criteria for another mental disorder
- Other disorders include adjustment disorder, depression, separation anxiety, general anxiety, attachment disorders, ADHD, and other behavior disorders.

Medicating Symptoms and Obfuscating the Substantive Issue

- ADHD
- Bipolar Disorder
- “Psychotic” symptoms
- Impulse Control Disorder
- Panic Disorder

Reasons for Misdiagnosis

- Failure to recognize trauma of physical and sexual abuse.
- Recognition of trauma-related symptoms requires a paradigm shift—from endogenous biological diseases or metapsychological conflicts—to one dealing directly with severe trauma.

Difficulties in Diagnosis

- Internal experiences are difficult to articulate
- Difficulty often in trusting an adult during therapy since "trusting adult" perpetrated abuse
- Resist disclosure—fearing further fragmentation of family
- Concern about disclosure of unusual symptoms since they may be viewed as "crazy"
- Symptoms may be confused with schizophrenia-like symptoms (Nurcombe, 1991)
- Symptom pattern may change over time
- Other symptoms may draw more clinical attention

PTSD Criteria

Arousal (2)
- Sleep
- Irritability
- Concentration
- Hypervigilance
- Startle
- Physiologic

Re-Experiencing (1)
- Recollections
- Dreams
- Seems to Recur
- Symbols

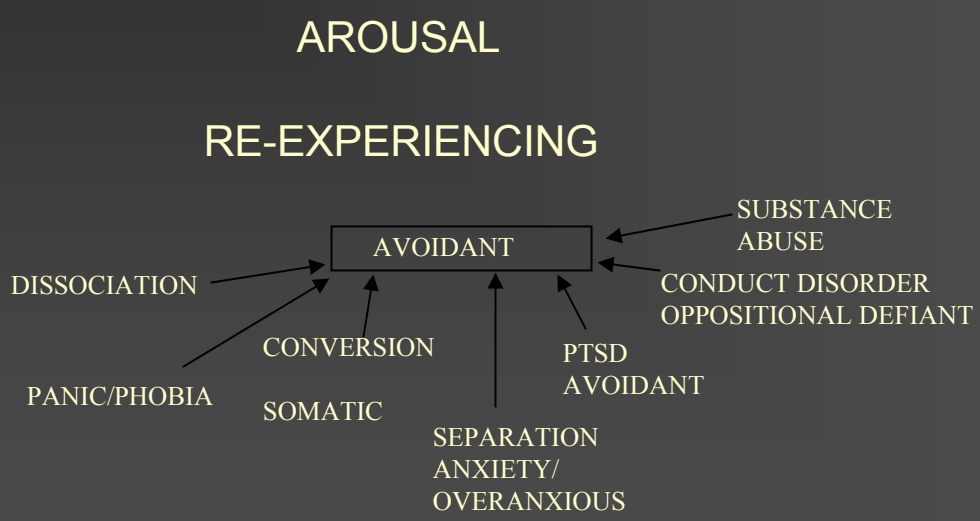
Avoidant (3)
- Thoughts/Feelings
- Activities
- Memories
- Interests
- Others
- Affect
- Future

Development of PTSD

- PTSD Over Time

Misdiagnosis and Comorbidity

- A PTSD Formulation for Children



Helping Traumatized Children

- Maintain normal routines as much as possible
- Tolerate retellings of the event
- Encourage children to express their traumatic experience
- Handle disturbing reenactments carefully
- Remain calm when answering questions and use simple, direct terms
- Don’t “soften” the information you give to children
- Avoid exposing children to unnecessary trauma reminders (e.g., media)

Helping Traumatized Children

- Help children develop a realistic understanding of what happened
- Gently correct misattributions (e.g., self-blame) about trauma
- Be willing to repeat yourself
- Normalize “bad” feelings
- Expect angry outbursts
- Address acting out behaviors involving aggression or self-destructive activities quickly and firmly
- Be patient with children and yourself

Helping Traumatized Children

- Reinforce ideas of safety and security
- Allow them to be more dependent temporarily if needed
- Follow their lead (hugs, listening, supporting)
- Use typical soothing behaviors
- Use security items and goodbye rituals to ease separation
- Distract with pleasurable activities*
- Let the child know you care

*normally occurring

How to Talk (and Listen) to Traumatized Children

- Children need to have their feelings accepted and respected
- Listen quietly and attentively
- Acknowledge their feelings with a word or two
- Give their feelings a name
- Give them their wishes in fantasy
- Show empathy

Responses That ARE NOT So Helpful

- Denial of feelings
- Philosophical response
- Advice
- Too many questions
- Defense of the other person
- Pity
- Amateur Psychoanalysis

Correcting Distorted Beliefs

- Point out the child's distorted belief by briefly summing it up
- Label how you think they might feel
- Validate their feeling; show empathy
- Let them know how it makes you feel to hear the distorted belief
- Suggest a healthier belief; keep it brief

Helping Parents of Traumatized Children

- Communicate with parents frequently about child
- Encourage parents to listen to child closely
- Encourage parents to set aside special time for the child
- Recommend maintenance of normal routine
- Encourage parents to remain calm and to get help for themselves if needed
- Normalize child's emotional/behavioral difficulties after trauma
- Model soothing behaviors with child
- Assist in developing plan for behavior mgmt.

Common Trauma-Related Distortions in Children

- Self-blame
- Guilt
- Shame/embarrassment b/c of trauma
- Shame over PTSD symptoms
- Hero fantasies related to trauma
- Overgeneralization of danger/risk
- Omen formation

Parental Involvement in Treatment

- Assessment feedback
- Psychoeducation
- Cognitive Processing/Cognitive Behavioral
- Behavior Management Training
- Joint parent-child sessions
  - Parent models positive coping with trauma
  - Parent assumes role of therapist as child's supporter related to trauma

Other Treatments for PTSD

- Group therapy
- Psychodynamic therapy
- Eye Movement Desensitization and Reprocessing (EMDR)
- Pharmacotherapy (SSRIs)
- Psychological Debriefing
- Play therapy
- Creative therapies (art, drama, music)
- Hypnosis

Traumatic Bereavement

- PTSD in the case of traumatic loss often impedes the grieving process. The person focuses on the traumatic death rather than the loss.
- After exposure, additional treatment components include recognition/acceptance of the loss, positive reminiscing, coping with future loss reminders, and addressing conflicting thoughts about the deceased.

Questions and Comments